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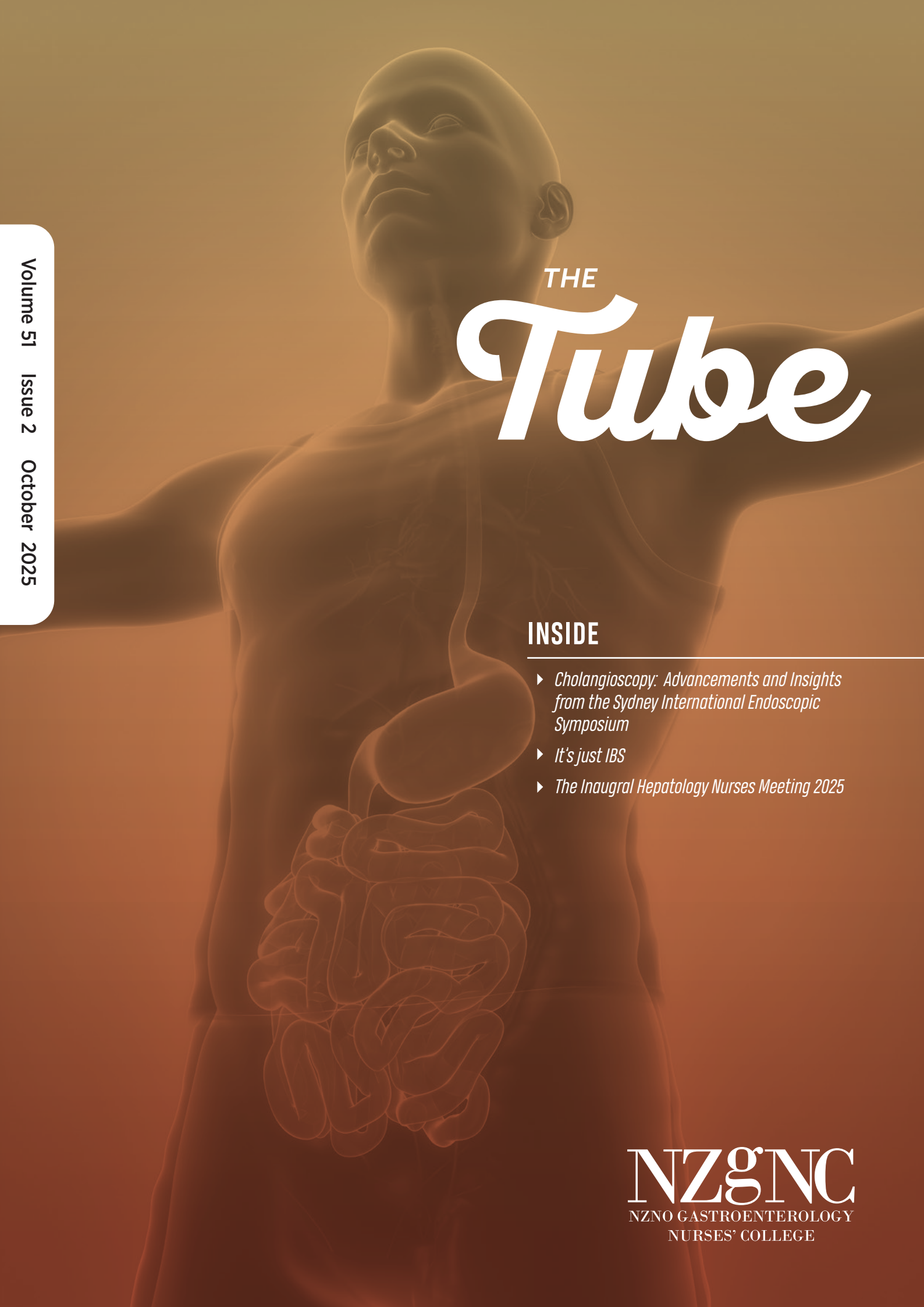
THE Tube



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OLYMPUS

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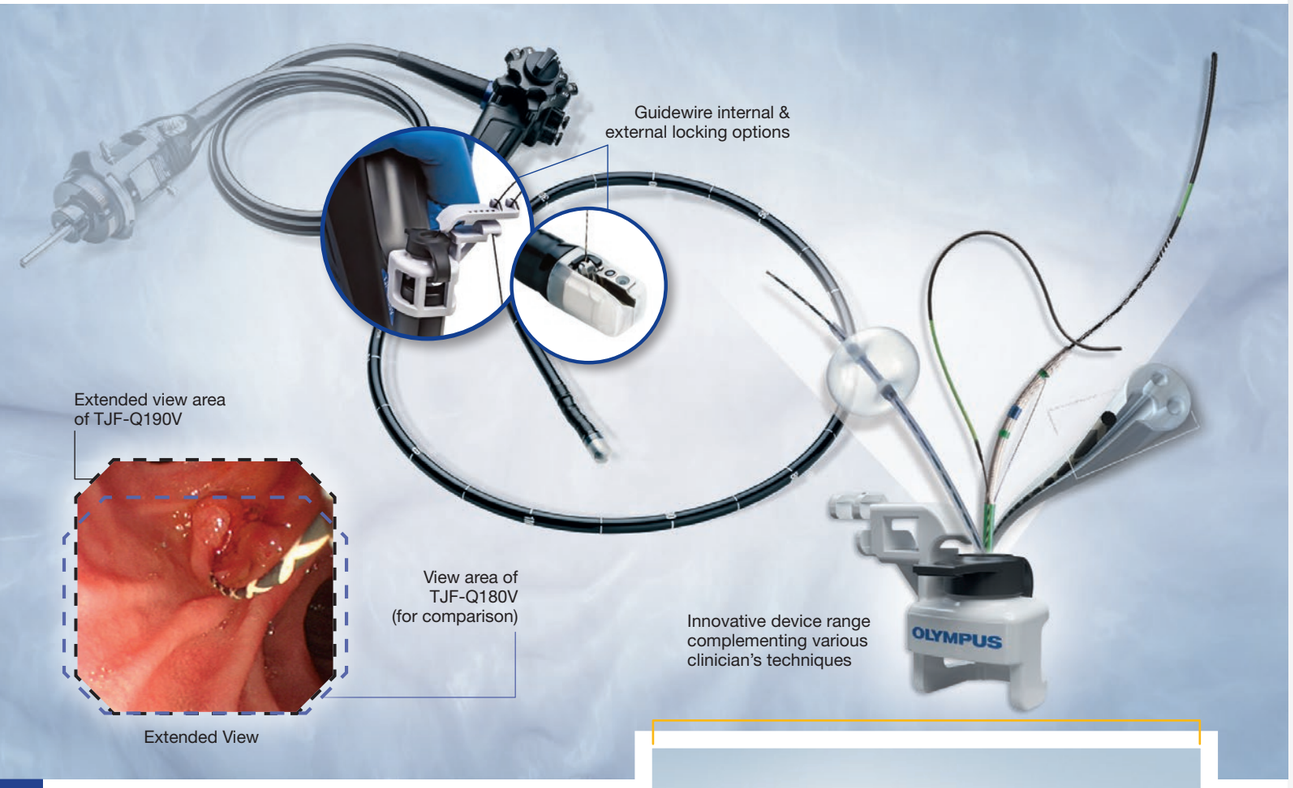
Every ERCP procedure presents its own unique challenges, Olympus provides both a duodenoscope and devices to maximise efficiency and clinical outcomes



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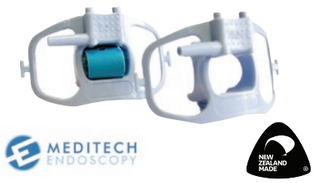

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NZNO NZGNC

Report from the new chairperson – Karen Kempin

Hello all and welcome to a busy edition of the Tube journal. It is only a month until our Annual Scientific Meeting in Palmerston North, with a very good nursing program, some great abstracts submitted for presentations and posters and, of course, our "reliving your youth" costume themed dinner. Hope to see you there and I am hoping to have some badges for the GNC committee members to wear so you can find us easily.

Recently I represented the NZ Gastroenterology Nurses College at the NZNO Annual General Meeting and Conference, held at Te Papa on the Wellington waterfront. I have written a more complete report for this edition of the Tube, but just want to encourage anyone who is reading this to consider volunteering or accepting if you are asked to attend as either a College or Section representative or as a regional delegate. As part of our MECA agreements negotiated by NZNO, you have access to paid leave to attend as a union representative and become involved in the democratic process and decision making by NZNO members. I felt informed, inspired and better equipped to appreciate the bigger picture of health in New Zealand after attending.

I would like to commend Natalie Pollock and Michelle Harman from Palmerston North Gastroenterology Unit for the hard work they are doing towards hosting the annual conference. If you follow the link here to the official meeting page, you can look at the quality programme that is taking shape. We have received many nurse abstracts that have either been accepted for free paper presentations or posters and remind you all that these people are in the running for awards with cash prizes for Best First Time Presenter, Best Overall Presentation and Best Poster. For anyone who has had an article published in this year's Tube editions, you are in the running for a prize for Best Article, with all of the winners announced at the conference dinner.

I would also like to prepare you all for an important announcement at conference regarding the history of the Gastroenterology Nurses College and paying respect to two amazing nurses who started our section/college and influenced the broad scope of practice that nurses have within the gastroenterology specialty. You will have to be there to hear it first.....

As a final thought I would like to draw your attention to the opportunity to join our committee for 2026. We have vacancies and are looking for anyone in the gastroenterology specialty area who is an NZNO and college member and wants to participate in college activities and projects. Being a committee member looks good on a PDRP portfolio, will help you raise your profile and is a great accomplishment in your resume. Nomination forms are available through our NZNO Gastroenterology Nurses College webpage or you can email secretaryofnzgnc@gmail.com to ask for the form. We are looking for people with good social media skills or ideas on implementing Sustainability and Te Tetiriti principles into our specialty, work in either the public or private sector, are clinical, research or management based or have any skills or ideas that will give direction to our college actions in the next few years.

See as many of you as possible in Palmerston North.

Karen Kempin
Your Chairperson
NZGNC Secretary **secretaryofnzgnc@gmail.com**

GENCA Fundamentals of endoscope reprocessing

New Zealand Dates 2026
20th February – Christchurch
5th June – Auckland
21st August – Wellington

Contact **fundamentals@genca.org** if you would like to inquire about having a workshop outside of these main centres.

New Zealand Society of Gastroenterology Inc | NZgNC NZNO GASTROENTEROLOGY NURSES' COLLEGE

ANNUAL SCIENTIFIC MEETING 2025

FLY PALMY ARENA
PALMERSTON NORTH
26 – 28 NOVEMBER 2025

The NZSG Annual Scientific Meeting is in Palmerston North on the 26th to 28th of November 2025. This is a great chance to engage with fellow professionals while exploring the beautiful "Mighty Manawatu" region.

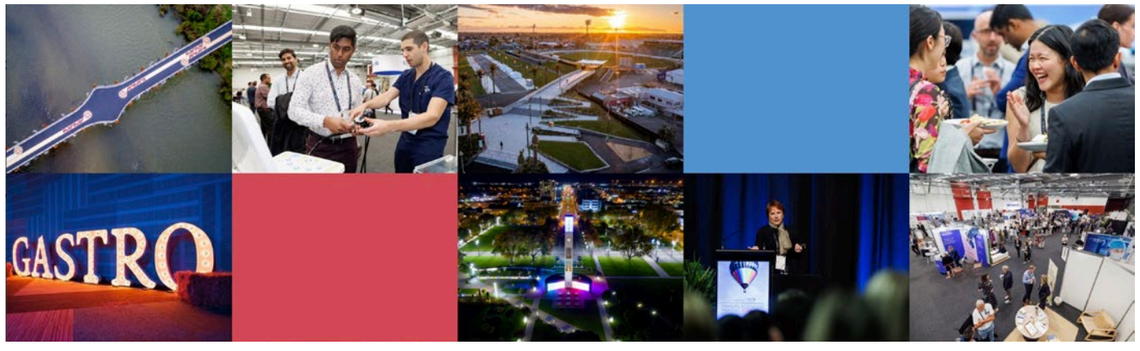
For those interested in outdoor activities, the area offers fantastic biking and hiking trails that showcase the stunning natural landscapes. Wind turbine enthusiasts can enjoy the iconic wind farms nearby, while sports fan can visit the Rugby Museum to learn more about New Zealand's rich rugby history.

Art lovers will appreciate the Te Manawa artspace, which features a diverse range of exhibitions, and there are plenty of charming cafes along George Street to relax and enjoy local cuisine. Additionally, garden tours and historic homes provide a glimpse into the region's heritage and horticultural beauty.

Make the most of your visit by planning some time to explore these attractions and immense yourself in the local culture or just come and relive your youth.

See you in Palmy!

Ngā mihi
2025 Organising Committee | Palmerston North Hospital



RŌPŪ TĀPUHI HEPATOLOGY O AOTEAROA
NZ HEPATOLOGY NURSES GROUP

NZ Hepatology Nurses Group

Hepatology Nurses Committee Update

It has been a busy and productive year for the Hepatology Nurses Group. Following the success of our inaugural Nurses Education Day held in Tāmaki Makaurau (Auckland), the committee is now looking ahead to 2026 for a follow-up event. Members reported that the value of meeting face-to-face in a dedicated space fostered collegiality and made the event an incredibly worthwhile educational experience.

We'll share more details once planning is underway—keep an eye out for the report from Chair Judith McLaughlin in the next edition of The Tube.

- As some committee members reach the end of their terms, we are delighted to welcome two esteemed colleagues: **Jen Chesbrough** and **Barry Harrison**. We are also deeply grateful to Bridget Faire, our outgoing secretary, for her extended support and expert contributions. Bridget will continue to share her exceptional knowledge and skills before stepping down later this year. Look out for more about our new committee members in The Tube.
- Our ongoing initiatives continue to gain momentum, with a strong focus on providing educational opportunities for our members. We hope to launch an online event soon, featuring topics of interest and facilitated case study discussions. Watch your inbox for updates!
- As we prepare for the upcoming **Annual Scientific Meeting in Palmerston North (26–28 November)**, we look forward to reconnecting with familiar faces and welcoming new members. We're excited about the nurse-led presentations and the valuable insights they'll bring to the field of hepatology.

NEW ZEALAND NURSE ENDOSCOPISTS ASSOCIATION

Nurse Endoscopists News

NZNEA has financially supported Alice Washer, Nurse Endoscopist at Middlemore to attend the Sydney International Endoscopy Symposium this year. Despite the meeting having a substantial quantity of interventional content (ie ESD) her recent report back to the NZNEA group at our quarterly meeting was very informative for us all, with updates on the latest opinions & evidence on cold snare vs hot snare polypectomy.

One of our other members, Debbie Perry from Auckland, has recently attended the Tripartite Colorectal Meeting in Paris and presented a poster. We will be giving her some funding to assist with accommodation and look forward to hearing about the experience.

We have also had a working group update the training pathway for Nurse Endoscopists, and these documents are in this edition of the journal. You can find them on the NZGNC, Nurse Endoscopist subgroup webpage – titled "Programme for Nurse Endoscopist Internship 2025 (updated training pathway)".

Our most recent meeting was 26 August 2025 online and our yearly NZNEA study day will be Tues 25 November (the day prior to Gastro Conference), at the Gastro Conference venue, Fly Palmy Arena.

If interested, you can join NZNEA by emailing us at nzneassoc@gmail.com.

Tania Waylen and Sofia Krylova Smith
Co-charpersons

Programme for Nurse Endoscopist Internship

This document is an updated summary of the Nurse Endoscopy Training & Credentialing Programme 2015, and the previous University of Auckland Nurse Endoscopy Training Pathway.

Prerequisites

It is essential Registered Nurses selected for this training programme have, as a minimum, completed a Postgraduate Diploma or be currently working towards it. The Postgraduate Diploma should include:

- Advanced assessment and diagnostic reasoning.
- Advanced biological science/anatomy and pathophysiology (gastrointestinal system focus to assignments).
- Pharmacology leading to nurse prescribing.
- Evidence based practice is recommended.

In addition to academic prerequisites the nurse:

- Must have minimum of 5 years clinical experience post registration.
- Must have advanced cardiac life support training.
- Preferably have experience in gastroenterology/endoscopy or related area such as colo-rectal surgery.

Preparation

NE intern should have a career plan written down and confirmed with nurse manager/clinical lead/management lead. This can be part of a performance appraisal.

- Should outline what other senior nurse roles they want to do, as well as endoscopy ie. IBD, Hepatology, PEG, IDA clinic, rectal bleed clinic, etc, etc.
- Plans for further post graduate progression such as Masters or NP.

Training Contract

NE intern should have a training contract signed by health region management, clinical lead and nurse manager confirming training supervisor, terms of training, duration of training, position as a CNS while training, supernumerary hours that will be replaced by another RN while training, outline of the role for the NE intern once training is completed. Some examples of things to include in contract:

- Named trainer
- 2 minimum training lists per week
- Release time to attend endoscopy clinics, surgical clinics, MDT, histopathology meetings and other training days or online training
- Two-year approximate training period
- Training in gastroscopy and colonoscopy
- Supernumerary position as intern
- CNS title and pay scale

- Use of DOPS, DOPyS, supervisor's reports from Conjoint Committee during training. https://nzsg.org.nz/training-resources/information-and-forms-for-endoscopy-training-recognition/
- CNS or better title and pay scale after training
- Support to complete Masters/NPTP during or after NE training, or completion of Postgraduate Diploma (consider inclusion of N717 Practicum for RN Designated Prescribers (UoA) or equivalent) prior to advancing to Masters/NPTP.

Assessment

- As per NZ Conjoint Committee requirements for recognition of training in endoscopy.

External/additional training

Required

- Advanced life support with 3 yearly updates
- Safe Sedation Training online from University of Utah

Strongly recommended

- NZSG Introduction to Endoscopy Course (face to face twice yearly options)
- NZSG Polypectomy Workshop (face to face yearly)

Also consider

- GESA Basic Knowledge for Colonoscopists (online)
- Specialist Gastroenterology Nursing (NSN124 Queensland University of Technology)

Mentor

There are sufficient practising NE's that a mentorship could be offered to NE interns as a direct line to ask questions, get suggestions, trouble shoot issues and offer support. NZ Nurse Endoscopists Association (NZNEA) are also available for support and have quarterly meetings.

NZNEA working party members are able to be contacted for guidance if needed.

Tania Waylen	Tania.Waylen@bopdhb.govt.nz
Sofia Krylova	Sofia.Krylova@waitematadhb.govt.nz
Nicola Griffiths	NicolaElizabeth.Griffiths@waikatodhb.health.nz
Alice Washer	Alice.Washer@middlemore.co.nz

Abbreviations:

Nurse Endoscopist, NE; Clinical Nurse Specialist, CNS; Nurse Practitioner, NP; Nurse Practitioner Training Pathway, NPTP; Registered Nurse, RN; Inflammatory Bowel Disease, IBD; Iron deficiency anaemia, IDA; Percutaneous endoscopic gastrostomy, PEG; Multi-disciplinary team, MDT; Direct observation of procedural skills, DOPS; Direct observation of polypectomy skills, DOPyS; University of Auckland, UoA; New Zealand Society of Gastroenterology, NZSG; Gastroenterology Society of Australia, GESA; New Zealand Nurse Endoscopists Association, NZNEA.

THE Tube

There are two pathways an organization can take when considering training and supporting a Nurse Endoscopist to join the workforce.

Nurse Endoscopist – Senior Nurse, currently falls under Clinical Nurse Specialist (CNS)	Nurse Practitioner/Endoscopist
Organisation supports the Nurse Endoscopist Internship Programme. Minimum of 5 years clinical experience post registration-is a NZ registered Nurse with a current APC. Advanced cardiac life support training. Preferably have experience in gastroenterology/endoscopy or related area such as colo-rectal surgery.	***Already practising (Nurse Endoscopist) training to perform Endoscopic procedures.*** Minimum of 5 years clinical experience post registration –is a NZ registered nurse with a current APC. Advanced cardiac life support training. Preferably have experience in gastroenterology/endoscopy or related area such as colo-rectal surgery.
Completed or working toward a PG DIP - Papers should include • Advanced assessment and diagnostic reasoning • Biological science • Pharmacology leading to nurse prescribing (if applicable) • Evidence based practice is recommended These papers (or those equivalent depending upon academic facility) are prerequisites for the Master of Health Science/Nursing.	A need has been identified within the service for a Nurse Practitioner Completed a PG DIP. Enrolled on Master of Health Science pathway leading to NPTP. As per NPTP requirements at least three years in speciality in which the nurse intends to prescribe. Support, funding and release time is available to complete the programme, as per NPTP requirements there is a role/job as a NP when programme completes.
Training Contract External/Additional training Mentor (See Programme for NE Internship for the above in detail) Conjoint committee recognition of training in Endoscopy The Nurse Endoscopist practices as a senior nurse/CNS performing endoscopic procedures independently. *the nurse prescribing formulary does not cover many of the medications utilized in endoscopy/Gastroenterology/Colorectal. Standing orders will be required for ongoing practice. Support from the individual organizational nursing and SMO teams is required. The nurse will progress to complete Masters Education – this ensures the Nurse Endoscopist: • Is at a level of advanced education/practice. • Provides the foundation for the future, should the nurse or organization agree that the NP pathway is the way forward.	***Nurse Practitioner pathway resources*** https://www.waikato.ac.nz/about/faculties-schools/health/nursing-uow/nurse-practitioner-pathway/ https://practitioner.nurse.org.nz/ https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/nursing/nurses-in-new-zealand/nurse-practitioners https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Nurse_practitioner.aspx

Please note: within the Nurse Endoscopist Internship programme, it is advised that the eligible nurse whilst training is in a supernumerary position (approx. 2 years dependent upon individual) – 1) This is to allow two training lists per week (in gastroscopy, flexible sigmoidoscopy and colonoscopy/polypectomy/therapeutics) and the ability to join other endoscopy lists ad hoc in addition to the two training lists. 2) Allowing for release time to attend Gastroenterology clinics, Surgical clinics, MDT, histopathology meetings and other training days or online training.

Cholangioscopy:

Advancements and Insights from the Sydney International Endoscopic Symposium

NIDAMRIC SEO-AS Registered Nurse
Gastroenterology Unit - Christchurch Hospital
nidamric.seo-as@cdhb.health.nz

I have had the privilege to attend the Sydney International Endoscopic Symposium (SIES) in March 2025, having been funded by the New Zealand Gastroenterology Nurses' College (NZgNC). I am truly grateful for their support. This is my first time attending the conference, and I enjoyed every bit of it. This article is about a procedure I watched while being performed live that struck me the most: Cholangioscopy.

Cholangioscopy is a cutting edge endoscopic method in which visualisation of bile ducts is made directly possible, allowing diagnosis and treatment of several biliary illnesses. At the 2025 SIES, Per Oral Cholangioscopy was performed in conjunction with Endoscopic Retrograde Cholangiopancreatography (ERCP) procedure by a single operator while trying to remove a large stone through lithotripsy.

What is Cholangioscopy?

Cholangioscopy is a noninvasive endoscopic method used for both direct visual diagnostic evaluation and therapeutic intervention of the bile ducts (Zhou Y, et al., 2017). It involves using a thin, flexible endoscope to see the bile ducts. It is most useful in diagnosing diseases such as bile duct stricture, stones, and tumours (Figure 1). By directly visualising the bile ducts, cholangioscopy enhances the specificity of diagnoses and allows intervention based on targeted criteria.

Cholangioscopy has two ways of access. Percutaneous cholangioscopy (PCS) and Per Oral Cholangioscopy (POC). POC done endoscopically is known to be less invasive and safe.

While three distinct per oral cholangioscopy techniques have been described, encompassing "dual-operator", "single-operator", and the "direct" technique using gastroscopes (Figure 2), it is the single-operator cholangioscopy that has garnered widespread acceptance as the gold standard for biliary system interventions. Its user-friendly design and widespread availability have contributed to its prominence in clinical practice. (Lopez P, et al. Al. 2024).

The Role of Cholangioscopy in Modern Endoscopy

At SIES 2025, experts discussed the role of per oral cholangioscopy in the future management of difficult biliary disorders. Traditional technique like Endoscopic Retrograde Cholangiopancreatography (ERCP) is limited to one-dimensional X-ray images.

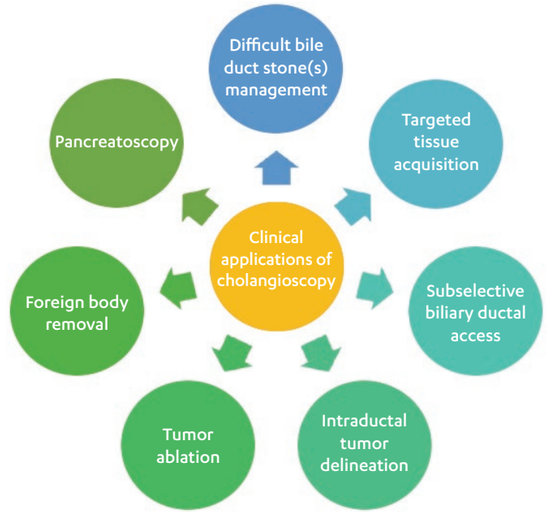


Figure 1. Common diagnostic and therapeutic applications of cholangioscopy (https://pmc.ncbi.nlm.nih.gov/articles/PMC8908329/)

Cholangioscopy is better as it delivers high-resolution, real-time bile duct images and therefore improves diagnosis and therapeutic efficacy.

Cholangioscopy would significantly improve patient outcomes by reducing the number of ERCP procedures required for each patient. In the future, it is likely to replace ERCP entirely, leading to a more cost-effective approach to diagnosing and treating bile duct disorders. Additionally, it would minimise radiation exposure for both patients and staff.

There are two main single-operator cholangioscopes in the market: the Spy Glass DS (Figure 3) and the Eyemax Single Operator cholangioscope (Figure 4). Both are single-use devices that have a working channel for instruments and irrigation/aspiration. These features set them apart from the traditional ERCP method. It's a significant advancement from wire-only guided access to directly using biopsies, snare, and lithotripsy devices through the cholangioscope's working channel(Figures 3 &4). Spy Glass has historically been the major player for cholangioscopes and has since been improved. In 2018, a third-generation SpyScopeTM DSII Catheter (Boston Scientific Corporation) featuring increased resolution and improved

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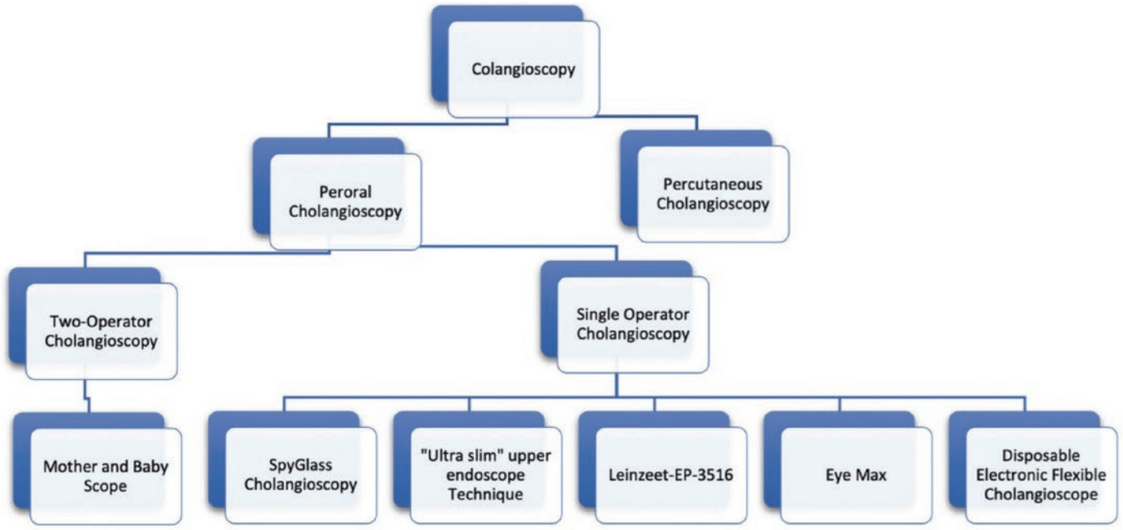

Figure 2. Types of Cholangioscopy (https://www.thieme-connect.com/products/ejournals/pdf/10.1055/s-0044-1787125.pdf)

lighting was introduced alongside new cholangioscopic accessories (Subash et al, 2022). Also, the emergence of new cholangioscope brands like Eyemax, manufactured by Microtech, is a positive development in the market.

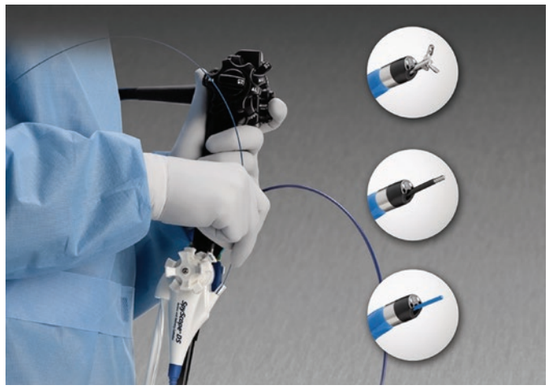

Figure 3. Spyglass DS (https://www.bostonscientific.com/en-US/products/single-use-scopes/spyglass-ds-direct-visualization-system.html)

Figure 3. Eyemax cholangioscope (https://emea.mtmed.com/wp-content/uploads/2023/09/EYEMAX_Cholangioskope_EN.pdf)

Basic Steps Cholangioscopy

At the SIES, we had the privilege to observe how the nursing staff in Westmead Hospital in Sydney prepare and assist for a cholangioscopy procedure.

Patients are generally restricted from food and drink for 8-12 hours for a cholangioscopy.

Most contemporary cholangioscopic procedures are performed with a disposable Cholangioscope via a peroral approach during endoscopic retrograde cholangiopancreatography (ERCP).

After testing the light and the dials of the cholangioscope, and flushing the channel with water for lubrication, the handle of the scope is strapped just below the duodenoscope working channel. An adequate sphincterotomy or balloon sphincteroplasty is indicated to allow passage of the cholangioscope. Then, the cholangioscope is advanced through the duodenoscope channel preferably over a previously inserted guidewire into the bile duct under fluoroscopic guidance.

Once the cholangioscope is in a stable position in the distal or middle common bile duct, irrigation with sterile water allows visualisation of the bile duct aided by four-way tip deflection. The cholangioscope is advanced over the guidewire to a targeted biliary site (Figure 4) before the wire is removed to allow optimal visualisation and to allow advancing any instruments through its channel if needed. (Kiwan, W et. al. 2023). The endoscopist will then use the cholangioscope to diagnose and collect samples to rule out cancer in the biliary tract. They can also treat gallstones and stones in the bile ducts. Additionally, investigation and treatment of any bile duct strictures(thru dilatation and stenting) can be achieved.

After the procedure, the patient can go home once the sedative wears off. The patient is advised to follow a diet with only clear liquids such as water, lemonade, tea or coffee without milk for the next 24 hours. The patient can resume his regular activities a day after the surgery unless otherwise instructed by the doctor. (https://www.drkiranpeddi.com/cholangioscopy).

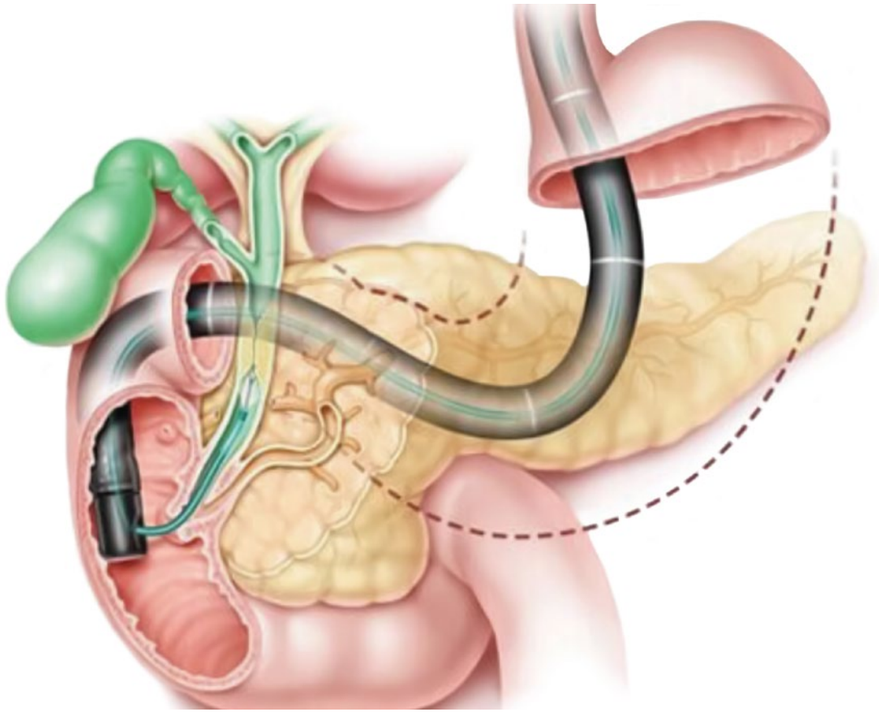

Figure 4. Cholangioscopy (https://www.drkiranpeddi.com/cholangioscopy)

Conclusion

Per oral cholangioscopy, using the single operator technique in conjunction with endoscopic retrograde cholangiopancreatography (ERCP), is undoubtedly the safest and least invasive approach to diagnosing and treating bile duct disorders. Direct visualisation is the main key for diagnosis and treatment. Moreover, the same endoscope can be used to visualise the pancreatic duct as well. The upgrades in camera resolution, the addition of the instrument channel and the ease of its use by a single operator are just a few specifications that contributes to these advantages.

While there are clear advancements in the cholangioscopy procedure, it is still performed infrequently in New Zealand. I have only heard of a few hospitals on the North Island offering this type of procedure, and none yet on the South Island. Christchurch Hospital is fortunate to have skilled endoscopists who are qualified to perform these procedures.

However, they lack the necessary instruments. One would hope that this technology will be available in the largest hospital on the South Island of New Zealand in the future. This would significantly improve patient care and outcomes, and it could also be a cost-effective measure for patients with difficult or complicated ERCP procedures.

Several years of experience in assisting ERCP procedures have led me to observe that certain patients would greatly benefit from this technology.

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- Eyemax cholangioscope **https://emea.mtmed.com/wp-content/uploads/2023/09/EYEMAX_Cholangioskope_EN.pdf**

NZNO Annual General Meeting and Conference 2025

The 2025 NZNO conference, including AGM, presentation of reports, keynote speakers and conference dinner happened on 17 and 18 September at Te Papa in Wellington. I had the privilege of attending as the representative for the NZ Gastroenterology College and for those who watch the news and social media, you will know I was present for an unprecedented protest to the words spoken by Health Minister Simeon Brown. It started with some attendees showing their disdain for the Ministers criticism of nurses protesting a deteriorating public health care system by standing and turning their backs to him. At the end of his speech, all conference attendees stood and stared at him in silence as he left the room. No applause or acknowledgement of his speech, just spine tingling quiet dignity and palpable unity in refuting his words, opinions, plans and actions. A moment to remember in my nursing career.

Photo Credit NZNO Kaitiaki 2025.

The AGM then moved forward with the presentation of annual reports, speeches from President Anne Daniels and Kaiwhakahaere Kerri Nuku and introductions of the newly elected board members, with thanks given to the outgoing members. There were no remits for this year but the executive indicated that the body of the conference was going to be presenting draft NZNO policies, with the AGM to open again at the end of the conference for voting. The goal is to change the direction of nursing and by default change the trajectory of the public health system to refocus on actual need and the physical, cultural and spiritual safety of patients.

The conference keynote speaker was David Stewart, who is the current Deputy Chief Nurse of the International Council of Nurses. He is also from Brisbane and currently maintains his nursing competence working in cardiology cath labs. He outlined that the ICN is refocusing on acknowledging and promoting first nations concepts of health and wellness in countries where nursing is entangled with a western medical concept of illness resolution and technology heavy healthcare, to the detriment of the native people and the broader population. He states that the ICN will be looking towards countries like Canada and New Zealand to guide and lead these changes to the model of nursing care. On a personal note I recognised David as being part of the Brisbane Metro North working group on Nurse GI Endoscopy, a project I was part of before coming to NZ in 2012. It is amazing how small the nursing world is sometimes!

The senior leadership team took the opportunity to introduce the new NZNO branding and colour schemes, developed and approved by the elected NZNO board.

CE Paul Goulter made a stirring speech, again rejecting the opinions of the Health Minister and the broader government about the state of the public health system and the misinformation campaign being waged in the media against nurses. He outlined the positive moves that NZNO is going to take in order to lead the change, rather than waiting for the government and other official bodies to set the agenda.

This lead to the outlining of the new policy suite, starting with deciding on "The Health System we need". The conference sessions ran by introducing each of the new draft policies, including presentations from the authors on why they choose these themes and goals. The floor was then opened to conference attendees to ask specific questions, make suggestions and even critique what was in the policy.

Below is the introduction from the overarching policy "Towards a Holistic Health and Wellbeing System and a World Class National Health Care Service". (NZNO 2025)

"What does a good public health system look like? Why is our health system falling so short? And how can we bridge the gap?

At a high level, answering the first question is relatively straightforward. It's what governments over many years have intended in their various health strategies and policy statements. Namely, high quality health care, accessible for all when needed, efficient, equitable, honouring Te Tiriti, 'people powered', and taking a whole-government approach to preventing poor health and promoting good health and wellbeing.

Nor is the failure to realise most of these aspirations to any significant extent difficult to understand.

Broken promises in health are by no means unique to Aotearoa New Zealand and the international literature highlights some issues that will resonate here, such as political short-termism, the vagaries of the political cycles, lack of engagement with communities and the workforce, and poor-quality political party policy-making, often lacking an evidence base and under-estimating the complexity of the delivery challenges.

The question of how we can get from where we are now to where we need to be is more of a challenge, but it can be done. It doesn't require major restructuring. It does require a shift in the mindset of policymakers and advisers to recognise the evidence supporting the substantial economic investment value in universal health care. It requires a more concerted effort to honour Te Tiriti, and it requires new ways of working across government and with communities, with a determined focus on developing a system of health protection and promotion, of which our national health care services are a critical part."

The conference sessions then progressively presented four main policies which are intended to achieve changes in the system that reflect the principles of equity and fairness that New Zealanders want to live by.

1. Te Tiriti – NZNO vision for a health system in New Zealand from a Te Tiriti o-Waitangi Perspective.

"This policy has been developed to support the New Zealand Nurses Organisation's (NZNO) strategic direction to actualise Te Tiriti o Waitangi and advance its Maranga Mai! Campaign (2023). It aligns with NZNO's commitment to equity, Māori health leadership, and mana-enhancing care, as outlined in the NZNO Strategy for Nursing (2018). NZNO is committed to a bold, Te Tiriti-based vision for the health system in Aotearoa. Our vision emerges from the clear and enduring failures of the health system to deliver equitable outcomes for Māori across generations, and the recognition that transformation, not incremental reform, is required. We affirm Te Tiriti o Waitangi as a constitutional covenant and assert that upholding tino rangatiratanga, embedding mana-enhancing practices, and transforming governance and service delivery structures are essential to achieving a just, equitable, and flourishing health system for all." Introduction to policy one NZNO 2025.

2. Public and Private Health

"The operation of the health system should be publicly funded and publicly provided. The 1938 Social Security Act, which created the publicly funded system, aimed to ensure health services would be free and accessible to all. An equitable and accessible health system cannot be one that is subject to market competition and market failure. Only through a public system can we create a system that works together, rather than one that operates competitively or at cross-purposes.

The government needs to commit to a fully-funded public health system and rule out privatisation as a solution. This would shift the dynamic where excess capacity in the private system results in siphoning public funds for low cost, low-quality healthcare.

The public health system can build capacity in funded sector health services by directly building infrastructure, employing workforce and delivering services that have historically been outsourced to the private sector such as primary health care and aged residential care." Context information for policy two, NZNO 2025.

3. Workforce – How many more nurses does New Zealand need?

NZNO commissioned "Infometrics – Economics put simply" to answer this question.

Full report can be found here but the goal was to find genuine shortage vs what the government is currently funding.

"Nurse vacancy numbers and vacancy rates provide estimates of the nursing shortage based on currently funded positions. However, if current funding levels constrain access to healthcare or are not sufficient for safe staffing (as feedback and studies across several settings such as general practices, mental health and addiction services, and hospices have found), then vacancies will under-estimate the genuine nursing shortage." Infometrics, 2025.

4. Role of the Nurse / Midwife

"The New Zealand Nurses Organisation (NZNO) Tōpūtanga Tapuhi Kaitiaki o Aotearoa seeks to articulate the Role of the Nurse / Midwife policy for the purpose of informing and influencing government, ministry policy settings, funding decisions and the delivery of health care and services across the health sector.

The role of the nurse / midwife has evolved over time, and has been defined through educational preparation, regulatory standards, scopes of practice, policy and public perception. NZNO's policy describes a future-focussed perspective, considering the challenges and current political climate in which nursing and midwifery exists." Introduction to policy four, NZNO 2025.

While the Infometrics report for policy three is available, the other policies are still in draft form and will undergo major changes from feedback given by conference attendees. Next steps will involve reworking and then broader release for review. This will be your opportunity to become involved so watch the regular NZNO updates and newsletters.

The final part of conference was a vote to adopt these policy themes. While there was robust discussion and critique, the five votes were carried by majority of those present at the conference.

I walked out of the venue feeling inspired and motivated to stay up to date on this major project and hopeful that nurses will be able to lead the change rather than waiting for other groups to decide what is needed. We are the biggest workforce in health and are tasked with speaking for our patients and each other when the care provided is inadequate and unsafe. This may be the solution, if we can speak and move forward together.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION

NZ IBD Nurses Educational Event

The NZ IBD Nurses Group organised an education event which was held over 5th and 6th September 2025, and was the 5th annual meeting. This year 27 IBD nurses from all over New Zealand, gathered in Auckland. The education days were held at North Shore Hospital in the Whenua Pupuke building situated on the boarder of Lake Pupuke.

A wide range of topics were covered over these days, to widen our current knowledge and keep our practice current. These education days also provide a place to bounce new ideas, network, support and empower each other in this constantly growing area of healthcare.

Drug representatives updated us on medications such as: Pentasa, Vedolizumab, Ustekinumab and Upadacitinab.

Dr Zoe Raos broke down the complexities of Primary Sclerosing Cholangitis, signs, symptoms and diagnostic testing and monitoring. Followed by a guest speaker who is a patient with both PSC and IBD. He shared his courageous journey from diagnosis, and how he manages the ups and downs. This patient blew us all away with his positive attitude and gratitude towards health care professionals.

Dr Mike Hayes discussed pouchitis and the medical management. Discussing current research around biologic treatment for this.

Navigating the overlap of IBD and IBS was explained by Anna Stanley, a nurse specialist zooming in from Australia. This was incredibly relevant as 30-40% of IBD patients have IBS symptoms.

Dr Kristine Ng clearly explained the potential clinical manifestation of joint pains and when to make a Rheumatology referral.

Donna Howe and Kirsten Arnold shared their wisdom on running a nurse led clinic and assessment.

Nideen Visesio shared a fascinating case study readings drug induced Lupus. This highlighted to all the importance of understanding the presenting symptoms of Lupus and when to intervene.

To top all of this wonderful learning off, Sonya English came to speak to us about mental fitness. We learnt techniques we can use each day to regroup, and reflect on how we as health professionals must incorporate self-care into our daily routines.

We are all incredibly grateful for the sponsorship from Jacqui and Tim Stone for a beautiful meal. This is an important opportunity for networking and continued discussions.

I would like to acknowledge the support from NZGNC along with the incredibly kind sponsorship from Pharmaco, Abbvie, Takeda, Johnson & Johnson. Their support makes this education day possible.

This vibrant group of nurses all have the same common focus – to care for, educate and support IBD patients with the most up to date evidence based practice. These study days have made me extremely grateful to be part of a group of nurses who support each other. This support is crucial for us to continue providing the best care to this ever growing patient population in IBD.

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It's Just IBS

Background

Irritable bowel syndrome (IBS) is a disorder of the gut-brain axis (DGBI) which results in heightened communication and sensation between the gut and the brain. The gut has been described as the 'second brain' and there is bi-directional communication between the gut and the brain.

The condition is diagnosed according to the following diagnostic criteria (ROME IV criteria).

Recurrent abdominal pain on average at least 1 day/week in the last 3 months, associated with two or more of the following criteria:

- Related to defecation
- Associated with a change of frequency of stool
- Associated with a change in form / consistency of stool

Criteria is fulfilled for the last 3 months with onset of symptoms at least 6 months prior to diagnosis. The BSG guidelines (2021) encourage that clinicians make a positive diagnosis based on symptoms in the absence of alarm symptoms and recommended that minimum investigations should include full blood count, CRP, coeliac serology and in patients <45 years old with diarrhoea a faecal calprotectin to exclude Inflammatory bowel disease. Alarms symptoms which would prompt further investigation with a colonoscopy include, unexplained weight loss, anaemia, pr bleeding, melena, and the presence of an abdominal or rectal mass.

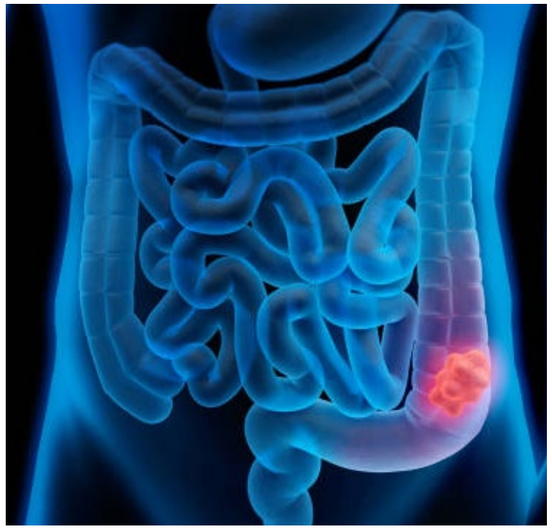
IBS is a disorder of pain and therefore individuals experience abdominal pain which is associated with a change in formation and / or consistency.

IBS is classified according to the following sub-types:

- IBS-D (diarrhoea predominant)
- IBS-C (constipation predominant)
- IBS-M (mixed pattern)

IBS is a common condition worldwide with a population prevalence of between 10-15% and is more common in women by 2:1. It is essential that at diagnosis, individuals are provided with a robust explanation of the condition to legitimise their symptoms, and explanation of the gut – brain axis. Dr Patricia Kaazan (Gastroenterologist, Adelaide) who presented at the GENCA conference referred to IBS as a 'disease of the function rather than the structure'. Dr Kaazan also identified the altered physiological process (listed below) which may be attributed to IBS and that it is important to explain and educate the patient on these.

- Motility disturbance
- Visceral hypersensitivity
- Altered mucosal / immune function
- Altered microbiota
- Altered CNS processing



In addition, the video by Professor Drossman is a tool which I use in clinic to explain the condition to individuals (see link below in Resource section)

Impact of the condition

The impact of IBS on individuals is as significant as any other chronic condition. There is an association with extreme anxiety in 40-60% of people with IBS as well as approximately 50% whom suffer with depression (three times more likely that the generally population). 3 out of 4 people who suffer with IBS report that it disrupts their life, with varying impact on their social, employment and psychological functioning. More than a quarter of all patients with IBS can wait more than 5 years for a diagnosis, according to Dr Simone Peters (Psychophysiologist, Melbourne), and this is despite the condition being prevalent, diagnosis can often be delayed.

Overview of Treatments

The treatment of IBS is largely focused on managing the most predominant symptoms for that individual (BSG 2021) and therefore assessing this clearly in clinic is key to be able to provide individualised treatment. In my clinical practice I also state at the outset of any treatment, that the treatment is aimed at 'improve rather than remove' and this helps to set the agenda clearly for the individuals. This is also acknowledging that IBS is a long-term condition and at times the symptoms will vary as episodes of stress and anxiety in individuals' lives will alter the disease activity.

Treatment strategies for IBS include dietary modifications, pharmaceutical therapy, psychological therapy (including CBT and hypnotherapy), gut neuromodulation. Education around the treatment options for individuals' is also key and this is where the nursing role often comes to the fore and helping to ensure motivation and commitment. Lifestyle management is a universal treatment for all sub-types of IBS and that included stress management, exercise, and adequate sleep and I often refer to these as 'tools in the toolbox' that again need to be individualised to best manage the condition in the long run.

Hypnotherapy

The use of gut directed hypnotherapy was presented at the GENCA Conference, by Dr Simone Peters (Psychophysiologist, Melbourne) and she highlighted that this is effective in 70-80% of individuals. With gut directed hypnotherapy the target is the subconscious mind with the aim being to control and normalise the gastrointestinal function. Within this type of hypnotherapy, the therapist used 'suggestions and metaphors'. Dr Peters explained that the mechanism of action of gut directed hypnotherapy is largely unknown, but that there is some evidence that it can reduce distal colonic motility. The time to respond is 6 weeks and if individuals do not respond in this time, then they are unlikely to respond thereafter.

A study by Anderson et al (2024) showed that digitally delivered gut-directed hypnotherapy was superior when compared to an active control group with greater improvements in both gastrointestinal symptoms and quality of life and provides an equitable alternative to face-to-face behavioural strategies. NERVA was recommended by Dr Peters which provides 6 weeks' program of gut-directed hypnotherapy to retrain the gut-brain connection, improving symptoms severity and long-term patients' outcomes. There is a fee for this program, with access to the platform for 12 months, via a mobile app. The time commitment for individuals using the platform is 15-20 minutes per day, over 6 weeks.

Furthermore, Dr Peters also referenced that hypnotherapy has similar durable effects to low FODMAP (Fermentable oligosaccharides, disaccharides, monosaccharides and polyols) for relief of gastrointestinal symptoms with superiority to psychological indices.

Dr Peters also identified that patient selection for hypnotherapy is important, as per the below table:

FAVOURED
Motivated and open individuals
Proficient in English
Mild / moderate anxiety
NOT FAVOURED FOR HYPNOTHERAPY
Lack of motivation or sceptical
Psychosis
Severe / unresolved trauma
Cognitively impaired

Conclusion

IBS is a common condition, and it is important that individuals with IBS are provided with access to treatment which can provide relief from their symptoms and gut-directed hypnotherapy has proven benefit in a significant proportion, provided it is considered in the right individuals. It is also key that individuals with are well educated on the condition itself (see resources below) and are supported to identify triggers (diet, stress, anxiety etc.) which impact on their condition, so that they can develop strategies to effectively self-manage in the long run.

Resources

NERVA Retrieved from URL **www.nervahealth.com**

Professor Drossman video link

Retrieved from URL Understanding the Brain-Gut Axis | This week, we discuss what the brain-gut axis really is and how it relates to DGBIs like #IBS | By Drossman Gastroenterology PLLC | Facebook

www.theibsnetwork.org.uk

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RŌPŪ TĀPUHI
HEPATOLOGY
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NZ HEPATOLOGY
NURSES GROUP

The Inaugral Hepatology Nurses Meeting 2025

On the 23rd of May we held our first Hepatology Nurses Meeting which was organised by nurses for nurses. We are very proud that most of our speakers were also nurses.

Topics included:

- Hepatitis B
- Assessment of Fibrosis & Clinically Significant Portal Hypertension (CSPH)
- Liver Transplantation
- Diabetes
- Metabolic Associated Steatotic Liver Disease (MASLD)
- Hepatocellular Carcinoma
- Alcohol Related Liver Disease (ARLD)
- Lipids
- A Dietitian and Health Psychologist presented also.

27 nurses from Whangarei to Invercargill attended the meeting and the feedback has been overwhelmingly positive. The committee is extremely encouraged to build on what we have learned and are already thinking about how we can put on an even better meeting in 2026.

Common themes

Well organized and relevant.

Very relevant to practice.

Appropriate level of content.

Networking valued.

Preference for an annual meeting.

MASLD talk popular and a desire for more on MASLD at future meetings.

Desire for more case studies.

Thank you to the hepatology team for arranging this and covering some very good topics/speakers, etc. 12

Thank you for a super thoughtful and well facilitated program! A great day, very useful. Thank you.

Thanks to the committee. Excellent relevant day

This was the most relevant study day I've had for Hepatology Nursing in my years of practice. Thank you, team!

If you would like to join the Hepatology Nurses Group, please email **nzhepng.secretary@gmail.com**

KEY DATES

Registration open
Wed 3 December 2025

Abstract submissions close
Fri 23 January 2026

Program launch
Wed 4 February 2026

Early Bird registration closes
Wed 1 April 2026

Welcome Reception
Fri 15 May 2026

GENCA 2026 National Conference
Sat 16 - Sun 17 May 2026

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Featuring expert-led education sessions, thought-provoking keynote speakers, and invaluable networking opportunities, the conference is your chance to connect, learn, and grow. Whether you're looking to expand your knowledge, share your expertise, or strengthen professional networks, this conference is your opportunity to be at the forefront of change.

Mark these key dates in your calendar and start planning your attendance today!

www.genca.org/education/2026-national-conference/

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THE Tube Writing Guidelines for Authors

The Tube is the official journal of the NZgNC (New Zealand Gastroenterology Nurses' College), and is published biannually. We welcome articles that will be of interest to nurses working in Gastroenterology and related. Our aim is to publish a high quality, professional and educational journal for nurses working within the specialty of Gastroenterology.

All manuscripts received by the editor will be acknowledged, however, reports, area news or letters to the Editor will not. If you have not received confirmation of receipt within six weeks, please contact the Editor.

Suggestions for articles include:

- Recommendations for nursing practice based on current global trends/literature
- Overview of learning achieved through post graduate paper, or conference attendance
- Review of literary article relevant to best practice
- Case study relevant to specialty
- Education for nurses based on sub specialty topic

EDITORIAL REVIEW/ACCEPTANCE

Articles submitted to The Tube are currently reviewed at a minimum by the editor and co-editor. The review will assess the accuracy of fact, clarity of presentation, use of references and relevance to practice of gastroenterology nursing. The editor/co-editor may also request a committee member review any article, particularly if the article is a sub-specialty of gastroenterology nursing and the committee member area of special interest/work.

All articles which are being considered for publication may be reviewed and returned to the author with suggestions for revisions and improvement. The author will be provided with a deadline in which to provide the revised article in order to comply with publication schedule.

The Editor's decision to publish or reject an article is final. You are welcome to email or phone the Editor to discuss your article should it not be accepted for publication.

STRUCTURE OF ARTICLE FOR SUBMISSION

The submission should include the following information:

Title Page

- Title of the Paper (20 word max)
- Author(s) name(s) in full
- Qualifications, current position, details of other relevant achievements, and affiliations of author(s)
- Address, contact telephone numbers, email address of the author(s)
- Conflict of interest and / or financial disclosure related to the article or related matter

Body of article

- Title at top of first page
- The body of work should be clearly written in an academic style of writing, and organised with headings/sub-headings (where appropriate)
- Pages numbered consecutively
- Tables, figures (if applicable) should be referred to in the body of the manuscript
- References (APA 6th Edition)
- Written authorisation(s) to publish identifiable person(s)/institutions and copyright materials

Word limit is approximately 1000 words. For the purposes of publication all articles should be formatted in Calibri, font size 10. All work should be saved as MS-Word (.docx) or text only (.txt) files.

All articles must be fully referenced where appropriate (APA 6th Ed)

Authors should keep an original copy of their article.

SUBMISSION

Articles should be submitted to the editor at NZGNC Secretary secretaryofnzgnc@gmail.com.

If submission of your article is as a requirement of a NZgNC Education/Travel Grant, please ensure you submit within the required 6 week timeframe of your funding application.

REQUEST FURTHER INFORMATION

For advice or clarification on any of the above matters please contact the NZGNC Secretary secretaryofnzgnc@gmail.com

COLLEGE COMMITTEE MEMBERS' REPORTS:

The aim of such reports is to inform the national College membership of the business and activities of the College during the last quarter.

These reports should include such activities as:

- College meetings/teleconferences (date and venue)
- Decisions arising from these meetings/teleconferences (can be focused on the minutes of these meetings)
- Plans/development the College is involved in/hopes to develop
- Any external meetings committee members have attended relating to the business of the College, e.g. meetings with NZNO professional nursing adviser/professional services manager
- Any contributions to national NZNO business, e.g. contribution to any submissions/ national guideline development

These should be a maximum of 600 words and contain people's correct names and titles.

CASE STUDY/CLINICAL PRACTICE ARTICLE:

- Outline the nature of the treatment/procedure/product that forms the basis of the case study
- Provide information on the patient: age, sex, history, any other pertinent clinical/social/cultural aspects. Avoid using information, which would clearly identify the patient.
- Tell readers what is new, interesting, different, pioneering, about this treatment/procedure/product
- Outline the actual treatment/procedure or how product works
- Report on the patient's/client's response/recovery/
- Tell readers what you have learnt through your involvement with this treatment/procedure/product
- Outline any implications/meaning it may have for gastroenterology nurses' practice
- Provide references to support the article.

THE Tube

NZgNC NZNO GASTROENTEROLOGY NURSES' COLLEGE

NEW ZEALAND NURSES ORGANISATION

ADVERTISING RATE CARD

The NZgNC is the national voice for gastroenterology nursing practice in NZ, and works collaboratively with the NZSG, and international societies such as GENCA and BSG. We represent nurses working in endoscopy, Hepatology, Inflammatory Bowel Diseases, Enteral Feeding, and Nurse Endoscopists

We have 2 epublications that are sent to our membership of more than 500 nurses

The TUBE e-magazine is the official journal of the NZNO Gastroenterology Nurses College and is published twice yearly. It features scholarly articles on all aspects of gastroenterological nursing including current research, education opportunities, reports from conferences, case studies, new medications and products, infection control and updates in clinical practice.

The PANUI newsletter is new for 2023 and is published 6 x per year. It is designed to be a snapshot update for our membership to print and place in their workplaces to keep teams up to date with education and learning opportunities coming up, clinical practice news, and general gastroenterology focussed news.

We welcome sponsor contributions to nursing education for Gastroenterology Nurses through advertising in our publications.

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Sponsor corner- $200 inc GST

SIZE AND DETAILS

The Tube:
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Half A4 Page- 180 x 120mm

The Panui:
Live link logo- to sponsor education content
Sponsor corner- 80 x 80mm with live link to sponsor www

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Spaces are limited for each publication.

Content deadlines for publication inclusions:

The Tube- **March Edition**	**Due date**- February 3rd
The Tube- **October Edition**	**Due date**- September 3rd
The Panui - **January, March, May, July, September, December**	**Due dates:** 1st of each month prior. Eg, 1st December, 1st February

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